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MEMORANDUM

TO:

Joint Legislative Oversight Committee Members on HHS	Commission for MH/DD/SAS
Local CFAC Chairs	State CFAC
NC Council of Community Programs	NC Assoc. of County Commissioners
County Managers	County Board Chairs
State Facility Directors	LME Directors
LME Board Chairs	DHHS Division Directors
Advocacy Organizations	Provider Organizations
MH/DD/SAS Stakeholder Organizations	NC Assoc. of County DSS Directors

FROM: Michael Watson

Steven Jordan SJ

SUBJECT: Implementation Update #98

Change in Provider Monitoring Tools	Auth Requests for Psychiatric Inpatient Acute Care
Provider Endorsement Ends	CON for Free-standing Psychiatric Hospitals/PRTF
NC-TOPPS Enhancements & Changes	Clarification Regarding Psychiatric Billing
SOC in 1915 b/c Waiver Environment	Extension for Provisionally Licensed
Medicaid Recipient Eligibility Verification	Clarification of DHSR Good Standing Status

Change in Provider Monitoring Tools

Effective July 1, 2012, the Frequency and Extent of Monitoring (FEM) Tool and the Division of Mental Health, Developmental Disability and Substance Abuse Services (DMH/DD/SAS) Provider Monitoring Tool will no longer be used by local management entities (LMEs) to conduct provider monitoring. LMEs that are not yet operating as managed care organizations (MCOs) have agreed as part of their transition process to adopt the PBH provider monitoring model effective July 1, 2012. LMEs that are operating as MCOs have already adopted PBH policy and procedures and are maintaining fidelity with the PBH model of monitoring.

Provider Endorsement Ends

House Bill 1055, signed into law and effective on June 26, 2012 eliminates the requirement for LMEs to conduct endorsement activities for providers. The credentialing process for LME-MCOs will replace the endorsement process previously performed by LMEs.

North Carolina Treatment Outcomes and Program Performance System Enhancements and Changes for SFY 2012-13

North Carolina Treatment Outcomes and Program Performance System (NC-TOPPS) will release version 2.1 July 2, 2012. As part of the recent NC-TOPPS Task Force, one of the major changes to the interview tool is the collection of service level data. On the initial interview providers will enter the service(s) the consumer is currently receiving and for each subsequent update they will select the service(s) the consumer is currently receiving as well as those received since the previous interview. Also during SFY 2012-13, NC-TOPPS will be working on enhancements to the Outcomes at a Glance dashboard as well as developing a secure query tool for LMEs and providers (based on their security role as defined in the system).

Below are some changes made to the *NC-TOPPS Guidelines* effective SFY 2012-13:

1) Change to determine which provider is responsible for NC-TOPPS when multiple providers are serving a consumer (now based on a hierarchy).

When a consumer is receiving more than one qualifying service, the responsibility for completing the NC-TOPPS interviews is determined by a hierarchy of services based on age-disability. The hierarchy is outlined below:

Adult SA/MH	Child/Adolescent SA/MH
Residential	Residential - PRTF
Partial Hospitalization	Partial Hospitalization
Assertive Community Treatment Team (ACTT)	Multisystemic Therapy Services (MST)
Substance Abuse Comprehensive Outpatient Treatment (SACOT)	Intensive In-Home Services (IIH)
Substance Abuse Intensive Outpatient Treatment (SAIOP)	Substance Abuse Intensive Outpatient Treatment (SAIOP)
Community Support Team (CST)	Child and Adolescent Day Treatment
Opioid Treatment	Residential – Level II (Program and Family Type) and Level III
Outpatient (IPRS SA Only): Individual Group Family	Outpatient (IPRS SA Only): Individual Group Family

Priority for the responsible provider agency is in hierarchical order so that if a consumer is receiving two or more of these services during a given period, the service that is in highest order on the table is responsible for NC-TOPPS. As services change within an episode of care, the NC-TOPPS record will be transferred to the provider agency providing the next highest service. Only one set of NC-TOPPS interviews is completed for each consumer during a particular episode of care.

2) Per the Task Force recommendation, when a provider prints off the submitted NC-TOPPS interview, the consumer must sign the interview before placing it in the consumer's record. If the consumer is not present for an in-person interview, then the interview will be placed in the consumer's record unsigned. Please note that if the provider conducts the NC-TOPPS with the consumer using the paper (printable) NC-TOPPS interview form, it is acceptable for the consumer to sign this printable form and place this copy in the record (along with the actual submitted interview form).

3) For LMEs that will continue to have MH/SA Targeted Case Management (TCM) (until becoming LME-MCOs in January 2013), the provider can capture this service in the "Other Category" in the website submission.

Child System of Care in 1915(b)/(c) Medicaid Waiver Environment

System of Care (SOC), as indicated in the State Plan and other DMH/DD/SAS policy documents is to be applied to all child and adolescent mental health/substance abuse services in North Carolina. The State of North Carolina (via the Divisions of MH/DD/SAS and Medical Assistance (DMA)) has long determined that System of Care is the management philosophy under which the State cares for North Carolina's children. It has been further agreed that Child and Family Teams (CFT) are a primary mechanism used to operationalize the SOC; Care Review Teams are an appropriate consultative mechanism to review high end plans, especially for out of home and out of state placements; and Community Collaboratives are the locus for pulling relevant and necessary decision makers (via family, Department of Public Instruction (DPI), Division of Social Services (DSS), Division of Juvenile Justice Department of Public Instruction (DJJDP), Division of Public Health (DPH), etc) to the table to coordinate and direct policy for children and adolescents in North Carolina. All of these elements should be part of an LME-MCO's business plan and evidence based philosophy.

DMH/DD/SAS has long promoted SOC within the LMEs and LME-MCOs by ongoing support via System of Care coordinators (funded by the General Assembly in 2006 as *fulltime, designated* positions). As part of North Carolina's system reform, via the 1915 (b)(c) waiver, and in light of recent Disability Rights North Carolina (DRNC) initiatives, SOC and the SOC coordinator are the mechanism to ensure the efficacy of the system, both fiscally and, more importantly, for the child and family. In order to further ensure this efficiency, the DMH/DD/SAS is evaluating a service-based functional alignment of funding that we believe is supportive of the SOC overall and the SOC coordinator in particular. The General Assembly initially allocated $2 million in recurring funding that was divided up between the then existing LMEs. That funding has never been diminished by DMH/DD/SAS and has continued to be allocated annually, albeit within the single stream context. Based on the number of covered children's lives (Medicaid, IPRS and Health Choice), DMH/DD/SAS will maintain the alignment of funding and SOC coordinator positions per LME as seen in the chart below.

LME-MCO Contract Recurring Requirement for Minimum Number of Dedicated Fulltime Child System of Care (SOC) Coordinator Positions: Effective July 1, 2012

LME Allocation			LME-MCO Allocation			
LME	**07/01/2006 CMH or SSF Allocation $ Amount for SFY 06-07**	**Required Fulltime Designated Child SOC Coordinator**	**LME-MCO**	**No. of Medicaid Eligibles Effective April 26, 2012**	**07/01/2012 SSF Allocation $ Amount for SFY 12-13 Upon Merger**	**Required Fulltime Designated Child SOC Coordinator(s)**
			CoastalCare	**79,222**	**133,334**	**2**
Onslow-Carteret	**66,667**	**1**				
Southeastern Center	**66,667**	**1**				
Western Highlands Network	**66,667**	**1**	**Western Highlands Network**	**83,771**	**66,667**	**1**
CenterPoint	**66,667**	**1**	**CenterPoint**	**87,008**	**66,667**	**1**
Smoky Mountain	**66,667**	**1**	**Smoky Mountain**	**92,002**	**200,001**	**3**
Foothills	**66,667**	**1**				
New River	**66,667**	**1**				
			ECBH	**105,790**	**333,335**	**5**
Albemarle	**66,667**	**1**				
Neuse	**66,667**	**1**				

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LME	07/01/2006 CMH or SSF Allocation $ Amount for SFY 06-07	Required Fulltime Designated Child SOC Coordinator	LME-MCO	No. of Medicaid Eligibles Effective April 26, 2012	07/01/2012 SSF Allocation $ Amount for SFY 12-13 Upon Merger	Required Fulltime Designated Child SOC Coordinator(s)
Pitt	66,667	1				
Roanoke-Chowan	66,667	1				
Tideland	66,667	1				
Mecklenburg	66,657	1	Mecklenburg	138,785	66,657	1
			Partners Behavioral Health Mgt.	157,131	200,001	3
Catawba	66,667	1				
Crossroads	66,667	1				
Pathways	66,667	1				
Sandhills	66,667	1	Sandhills	165,177	133,334	2
Guilford	66,667	1				
Eastpointe	66,667	1	Eastpointe	199,767	266,668	4
Edgecombe-Nash	66,667	1				
Southeastern Regional	66,667	1				
Wilson-Green	66,667	1				
			Alliance Behavioral Healthcare	218,397	266,668	4
Cumberland	66,667	1				
Durham	66,667	1				
Johnston	66,667	1				
Wake	66,667	1				
PBH	66,667	1	PBH	218,796	266,668	4
Alamance-Caswell	66,667	1				
Five County	66,667	1				
OPC	66,667	1				
Total	$2,000,000	30		1,558,711	$2,000,000	30

Medicaid Recipient Eligibility Verification Tools

A N.C. Medicaid recipient's eligibility status may change from month to month if financial or household circumstances change. For that reason, providers of behavioral health services should verify the recipient's county of eligibility using one of the recipient eligibility verification tools. These tools include a web-based tool, automated voice response system (AVRS), and real time eligibility verification (270/271 Transaction). These tools are described on the N.C. Division of Medical Assistance (DMA) Website at: http://www.ncdhhs.gov/dma/provider/RecipEligVerify.htm.

Please note that as of April 2012, the Medicaid card for new recipients and the updated annual card for current recipients includes the name of each recipient's LME-MCO, which is based upon their N.C. Medicaid county of eligibility. In addition, the AVRS has been updated to include the recipient's LME-MCO.

Authorization Requests by Psychiatric Inpatient Acute Care Providers: Psychiatric Hospitals and Psychiatric Residential Treatment Facilities

Note: The following article does not pertain to recipients covered under the 1915 b/c waiver.

Requests for authorization of inpatient start dates must be submitted to the utilization review (UR) vendor no more than two business days from the date of admission in order for the authorization to begin on the date of admission.

Requests received after the second business day following the date of admission will be authorized to start no earlier than the date the request was received. For example, if a recipient is admitted on Friday, the request must be received by the end of the day on Tuesday. Requests received on Wednesday will have a start date no earlier than Wednesday (date of receipt).

When making the authorization request in the vendor's web-based system, a correct "Requested Start Date" is essential; UR vendors review requests beginning with the providers' Requested Start Date and incorrect requests may result in loss of potentially authorized days. Please note: **The ValueOptions ProviderConnect system will default the Requested Start Date to the date of submission if the start date is not specifically entered by the provider.**

Concurrent requests must be submitted prior to end of the current authorization in order to be reviewed for authorization for the dates of service. A late submission resulting in unauthorized days requires splitting the stay for claims payment purposes. **Retrospective authorization resulting from late submissions is not permitted.**

Certificates of Need for Free-standing Psychiatric Hospitals Serving People under the Age of 21 and Psychiatric Residential Treatment Facilities

Effective August 1, 2012, Certificates of Need (CONs) for free-standing psychiatric hospitals (including state facilities) serving people under the age of 21 and Psychiatric Residential Treatment Facilities (PRTFs) **must** be signed and dated on the date of admission. A copy of the CON **must** be submitted to the UR vendor as part of the prior authorization request. The UR vendor can only begin the authorization on the date of the **last** signature on the CON.

Federal regulations require a CON form to be completed for admissions of Medicaid recipients under the age of 21 to a psychiatric hospital or PRTF. (Refer to 42 CFR 441.152 and 441.153 for detailed requirements). It is vital that this CON meet all the federal requirements and that the original completed form be maintained with the recipient's medical record for inspection during federal or state audits.

The state-approved CON form is required for psychiatric hospitals and PRTFs. Federal regulations require that the team providing the CON must include, at a minimum, a board-eligible or board-certified psychiatrist and one of the following:

- a psychiatric social worker (licensed clinical social worker);
- a registered nurse with specialized training or one year's experience in treating people with mental illness;
- an occupational therapist who is licensed and has specialized training or one year of experience treating individuals with mental illness;
- a psychologist who has a master's degree in clinical psychology or who has been certified by the state or by the state psychological association.

For additional information on the composition of the team, refer to 42 CFR 441.156.

Use the following UR vendor links to obtain a copy of the correct CON form.

- **ValueOptions:** http:www.valueoptions.com/providers/Network/North_Carolina_Medicaid.htm

- **Eastpointe:** http://www.eastpointe.net/
- **The Durham Center:** http://www.durhamcenter.org/index.php/provider/index/phome

Clarification Regarding Psychiatric Billing

Psychiatrists can bill using the physician codes on the fee schedule designed for medical doctors or doctors of osteopathy. The following link connects to that fee schedule: http://www.ncdhhs.gov/dma/fee/phy_fee/phy_fee_sch042412.pdf.

As a reminder, many of the evaluation and management (E&M) codes count toward the 22 visit annual limit. The link below provides a list of any codes that count toward the annual visit limit, as well as a list of recipients who are excluded from the annual visit limit, such as children with serious emotional disturbance (SED) and adults with severe and persistent mental illness (SPMI): http://www.ncdhhs.gov/dma/provider/AnnualVisitLimit.htm.

Please remember that all billing must be within the scope of the physician's training and that physicians must bill using codes that accurately reflect the services performed.

As a reminder, under managed care (the 1915 b/c waiver), all psychiatrist authorization requests and billing must be submitted to the LME-MCO. Please see the March Special Medicaid Bulletin http://www.ncdhhs.gov/dma/waiver/SpecialMedicaidBulletinMarch2012.pdf or Special Implementation Update #96 http://www.ncdhhs.gov/mhddsas/implementationupdates/update096/special_iu96final.pdf for additional information.

Extension of Coverage for Provisionally Licensed Providers Billing Outpatient Behavioral Health Services through the Local Management Entity

The coverage of provisionally licensed providers delivering outpatient behavioral health services as a reimbursable service under Medicaid funds and billed through the LME has been extended to June 30, 2013. The HCPCS procedure codes that may be utilized to bill for services delivered by the provisionally licensed individuals billing through the LME are H0001, H0004, H0005, and H0031. Provisionally licensed professionals billing HCPCS codes should use generally accepted guidelines for timeframes for individual outpatient sessions (generally 45-60 minutes) and group outpatient sessions (generally 90 minutes). Overuse of HCPCS code billing is being monitored by the DMA Program Integrity (PI) as part of federal Medicaid fraud initiatives. Providers should also review the March 2011 Medicaid Bulletin for guidance on counting unmanaged visits and requesting prior authorization.

Given the recent passage of House Bill 1081 (Provisional Licensure Changes Medicaid), DMA will be submitting State Plan Amendment changes to the Center for Medicaid and Medicare Services (CMS) to enable direct billing for licensed clinical social worker associates, licensed clinical addictions specialist associates, licensed professional counselor associates, licensed marriage and family therapist associates and licensed psychological associates. DMA will publish guidance for enrollment, billing and transition steps in an upcoming Medicaid bulletin.

Clarification of the Division of Health Service Regulation Good Standing Status

The Division of Health Service Regulation (DHSR) has provided clarification on their definition of good standing status. Effective immediately, DHSR good standing status is associated with a facility, not an entire agency or an individual associated with an agency or facility. DHSR determines if a facility is in good standing based on current and active administrative actions against the facility.

Actions included in the determination that a facility is not in Good Standing are included below:

- Active Type A or Imposed Type B, based on Provider Penalty Tracking Database [criteria in NCGS 122C-23(e1)-non-compliance in Article 3, Client Rights].
- Current Intent to Revoke - the Intent to Revoke is active and has not been rescinded.
- Active Suspension of Admissions - the Suspension of Admissions has not been lifted.
- Active Summary Suspension - the Summary Suspension was issued and has not been lifted.
- Active Notice of Revocation - the Notice of Revocation is current, and may be in appeal.

- Revocation in Effect - a Notice of Revocation was issued and the final outcome is that the license for this facility has been revoked and is no longer active.

LME-MCOS who are determining good standing status from DHSR in order to contract with agencies under the 1915 b/c waiver will receive a copy of the Good Standing Notice to assist in the determination of good standing. (See http://www.ncdhhs.gov/dma/forms/Good_standing.pdf to review notice.) For facilities that are not in good standing, LME-MCOs can pend their decision to contract with the specific facility for 90 days. During this 90 day period, LME-MCOs can check back with DHSR to determine if any resolution or changes to the action associated with the facility has occurred prior to making a final decision regarding the provider contract.

As a reminder, all Medicaid-enrolled providers billing for services are expected to adhere to all Medicaid and Health Choice policies and guidelines and are expected to stay informed about any changes. Medicaid Bulletins are published monthly and may include articles not found in the Implementation Updates. Medicaid Bulletins can be found at: http://www.ncdhhs.gov/dma/bulletin/index.htm.

Unless noted otherwise, please email any questions related to this Implementation Update to ContactDMH@dhhs.nc.gov.

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